

PHYSICIAN'S REPORT

TO BE COMPLETED ONLY BY A PHYSICIAN

Name of the patient _____
 Date of birth: Day _____ Month _____ Year _____ Female Male
 Blood pressure _____ MM/HG Height (cm) _____ Weight (kg) _____ Pulse rate _____

CLINICAL EVALUATION

Please indicate if the patient has experienced any problems with the following:

	Yes	No	Details
1 Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
2 Head, neck & thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
3 Eyes & ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
4 Mouth & throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
5 Chest, breast & lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
6 Heart & blood vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
7 Digestive system	<input type="checkbox"/>	<input type="checkbox"/>	_____
8 Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	_____
9 Skeletal, muscular system	<input type="checkbox"/>	<input type="checkbox"/>	_____
10 Urinary, reproductive system	<input type="checkbox"/>	<input type="checkbox"/>	_____
11 Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other comments _____

REQUIRED LABORATORY TESTS / INFORMATION

Tuberculin skin test (TST). Please indicate date and result in mm _____ or blood test: _____

Has the applicant been immunized against any of the following. Please specify the dates and number of doses.

	Yes	No	Dates	Doses
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis (BCG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

GENERAL IMPRESSION

The undersigned doctor certifies that the general state of health, physical and mental condition of the applicant are excellent, that he/she is not a carrier of any infectious disease and has no physical disability. The applicant can therefore comply, without risk, with the strict requirements of professional training in the hospitality industry. The undersigned doctor also certifies that the candidate is not obliged to follow a special diet.

Date _____ Doctors's signature and stamp _____